



CHOOSING A DRUG PLAN: IT'S NOT JUST THE PREMIUM THAT MATTERS

The recent announcement by the Centers for Medicare & Medicaid Services (CMS) that some Medicare prescription drug plans may have premiums of \$20 per month or less seems like a victory for Medicare Part D.¹ However, this announcement needs to be analyzed more closely.

While some low-cost plans are likely to be available in 2006, the general expectation is that beneficiaries' choice of plans will be reduced in future years as plan sponsors jettison their least profitable plans. We know from experience with the Medicare+Choice (now Medicare Advantage) program that private health plans frequently change premiums, cost-sharing, and benefit structure as Medicare reimbursement and the number of plans in a given market change.

Choosing a Part D plan, even for 2006, will involve an evaluation of many factors in addition to the amount of the monthly premium. Factors to consider include the following:

- **Formulary:** Does the plan include the particular drugs, in the appropriate strengths and dosages, that are currently used by the beneficiary? (Of course, a beneficiary cannot predict prescription drug needs from unanticipated medical conditions that occur in the future.)
- **Utilization management tools:** What are the plan's prior authorization requirements? Does the plan require that a beneficiary try particular medications before those prescribed by the physician (so-called "step therapy")? Does the plan charge different co-payment amounts for generic and brand-name drugs or different co-payment amounts for different drugs ("tiered cost-sharing")? How many cost-sharing tiers does the plan use? Does the plan have different co-payments or different co-insurance payments for each tier? In which tier do the beneficiary's current drugs fall?
- **Quantity limitations:** Does the plan limit the number of prescriptions a beneficiary may get in a month? Does it limit the number of pills or other dosages available in a single prescription?
- **Deductible:** What is the deductible? Will it be the standard \$250 or lower? How does the cost of the drugs that the beneficiary currently takes compare with the deductible amount?
- **Pharmacy:** Is the beneficiary's customary pharmacy included in the plan's network? Is the beneficiary's long-term care facility's pharmacy included in the plan's network?
- **Pharmacy costs:** Does the plan distinguish among pharmacies within its own network? Will a beneficiary be required to pay more for using a non-preferred network pharmacy?
- **Mail order:** Does the plan allow or require beneficiaries to use mail-order? Is there a price differential for mail-order purchases?
- **Transition process:** What rules does the plan use for temporarily providing drugs that are not covered by the plan during a "transition" process? How long is the transition period?
- **Exceptions process:** What process does the plan provide that beneficiaries may use to persuade the plan to cover a particular prescription drug as "medically necessary" even though the drug is not otherwise available for plan members?
- **Plan sponsor:** Is the plan sponsor a known, reliable entity?
- **Coordination with State Pharmaceutical Assistance Program:** How do the plan's benefits coordinate with Illinois Cares Rx?

After carefully balancing these factors, a beneficiary may very well conclude that the plan with the cheapest monthly premium may not be the best value. A person with a low-premium, low-deductible Part D plan who (now or later) needs a drug that is not on her plan's formulary – and who cannot use the drug that is on the formulary – may find herself spending more on her prescription drugs than ever.

¹ HHS, “Medicare Drug Plans Offer Premiums of \$20 Per Month or Less, Lower Deductibles, Enhanced Coverage Also Available” (News Release, Aug. 29, 2005).

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